HOUSING SPECIALIST

-Job Description

-Protected Health Information (PHI)

-DMH Policies

HOUSING SPECIALIST

A Housing Specialist develops a wide array of housing opportunities to meet the needs of consumers at various stages along the continuum of recovery, by working with landlords to identify and increase housing opportunities for people with mental health disabilities. Housing specialists additionally provide housing advocacy and housing location assistance to individuals and families that are homeless and individuals that want to move from their current location such as an Adult Residential Facility, Sober Living Home or other community setting to another, often more independent setting.

ESSENTIAL DUTIES:

- Outreach to property owners and managers in order to provide educate about mental health thereby reducing the stigma associated with mental illness and increasing the availability of housing opportunities in the fair market
- Develop housing resource lists for designated service area
- Avert possible evictions by maintaining professional relationships with property owners and managers and promptly addressing their concerns
- Educate individuals about available housing resources and assistance
- Assist individuals in completing applications for rental subsidies such as Section 8 and Shelter Plus Care, housing programs or private rental agreements
- Assist in the housing search process including but not limited to accompanying and assisting individuals with housing searches, identifying potential shared housing opportunities as preferred or necessary (because of financial constraints)
- Assist individuals to prepare for interviews with managers and property owners
- Provide referrals to appropriate housing resources
- Educate clients about tenant's rights and responsibilities and advocate for clients with landlords when tenant's rights have been violated.
- Liaison among clients, case managers, jail linkage specialists, the systems navigation team, peer bridgers, LAHSA. property owners and managers
- Advocate and negotiate for clients with poor credit and poor housing histories (i.e. evictions or lack of housing tenancy)
- Work closely with case managers to assist with housing retention efforts and facilitate communication among the involved parties

Qualifications:

- Strong communication, relational and negotiation skills
- Knowledge of the local community
- Working knowledge of housing law
- Highly energetic, capable of educating and promoting the recovery model amongst all community stakeholders
- Ability to assess properties
- Creativity in finding and developing housing options for people which provides the greatest chances of success
- Ability to multi-task
- Ability to work both independently and within a team

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT
HOUSING ASSESSMENT FORM

Last Name..... First Name..... MIS# ..... Sex.....

Date of Assessment:..... Social Security# ..... Date of Birth.....

Age..... Ethnicity Background:..... Psychiatric Dx.....

Source(s) of Income..... Monthly Income..... .....

Current Address.....

.....

Home Phone# ..... Cell # .....Work#.....

Estimated Relocation Time (days/weeks/months):.....

Case Manager/Navigator's Name:.....Clinic: .....Service Area.....

Current & Preferred Living Conditions

1. Current Residence

☐ Homeless – No shelter	☐ Board and Care	☐ Drug Tx Program
☐ Winter/All-year-round Shelter	☐ Residential Treatment	☐ Housing alone or with others
☐ Specialized shelter Beds	☐ Transitional Housing	☐ Project Based Section 8 Housing
☐ Temporarily housing in a motel	☐ Sober Living/Shared Housing	☐ Tenant based Section 8 Housing

2. Preferred Housing type

☐ Homeless – No shelter	☐ Board and Care	☐ Drug Tx Program
☐ Winter/All-year-round Shelter	☐ Residential Treatment	☐ Housing alone or with others
☐ Specialized shelter Beds	☐ Transitional Housing	☐ Project Based Section 8 Housing
☐ Temporarily housing in a motel	☐ Sober Living/Shared Housing	☐ Tenant based Section 8 Housing

Housing History Patterns

3. Describe client's living arrangements for the past five years:
(Include periods of homelessness, incarceration, hospitalization, shelter and residential programs, rehabilitation/detox centers)

Month(s)/Year(s)	Location
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT
HOUSING ASSESSMENT FORM

Independent Living Skills

4. How would you rate the client's ability to communicate and interact with others in the public?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

5. Indicate which activities and/or services that client **cannot** effectively execute access and/or utilize?

☐ Bathing
☐ Care of Personal Hygiene
☐ Cooking/Preparing Foods
☐ Laundry
☐ Housekeeping/Cleaning
☐ Personal Safety/Fire/Home
☐ Access to Healthcare and Medical issues
☐ Access Grocery Stores
☐ Public/Private Transportation
☐ Use of public facilities(i.e post office)
☐ Budgeting/Banking/Money Management
☐ Social Skills/Interpersonal Relationships
☐ Control Emotions and Impulses
☐ Comfortable Access Crowded Places for Services
☐ Make Sensible Judgments And Decisions
☐ Paying Rent
☐ Maintain Pertinent Personal Documents and Files
☐ Live Independently w/ No Assistance
☐ Walk a Reasonable Distance
☐ Wait patiently in line for services

6. The reason that client cannot effectively execute this/these activities (ies) are due to Medical or Psychiatric Disability? Yes ☐ No ☐ If yes, please specify

_____

Psychiatric Information

7. What is the client's Psychiatric Diagnosis?

Axis I (please specify)	and/or	Axis II (please specify)

8. List the Names and Dosages of All Psychotropic Medications the Client is Currently Taking

Name	Dosage	Name	Dosage

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT
HOUSING ASSESSMENT FORM

Medical Information

9. Does client report having any of the following communicable infections?

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Tuberculosis

☐ HIV/AIDS ☐ Other (specify) ☐ Hepatitis C ☐ Tuberculosis

10. Does client report having any of the following medical conditions, which affect their daily life?

☐ High Blood Pressure ☐ Diabetes ☐ Head Injury ☐ Legally Blind

☐ Legally Deaf ☐ Not Ambulatory ☐ Other (Specify)

Substance Use History

11. Indicate substance(s) the client reports to be currently using or has used in the past.

☐ Cocaine ☐ Marijuana ☐ Opiates ☐ Methamphetamines

☐ Alcohol ☐ LSD ☐ Mushrooms ☐ Ecstasy

☐ Others (please specify) _____

12. Date client reports last use: (month/year):_____ 13. Current Sobriety Time:_____

13. List All Issues, Events Persons and Locations/Geographic Area that Client Reports that his/her Substance Use is Encouraged by:_____

_____

_____

14. List the Name(s) and Contact Information of Recovery Programs that Client is Currently Enrolled/Involved In (include locations of AA/NA Meetings that the client constantly attends):

_____ _____

_____ _____

_____ _____

_____ _____

Statement of Client's Agreement

I,_____, (print client name) agree that all statements reported are factual information that can and will be used by the Department of Mental health (DMH) to assist me in locating emergency/transitional/permanent housing. I understand that DMH is responsible for assisting me in locating housing and is not committed to any financial responsibility associated with maintaining my housing unless otherwise specified and arranged by DMH

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

CLIENT:

Name of Client/Previous Names	Birth Date	MIS Number
Street Address	City, State, Zip	

AUTHORIZES:	**DISCLOSURE OF PROTECTED HEALTH INFORMATION TO:**
	Potential landlords and employers participating in the DMH Housing and Employment Programs
Name of Agency	Name of Health Care Provider/Plan/Other
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code

INFORMATION TO BE RELEASED:

___ Assessment/Evaluation ___ Results of Psychological Tests ___ Diagnosis
___ Laboratory Results ___ Medication History/ ___ Treatment
___ Entire Record (Justify) Current Medications
_X_ Other (Specify): The fact that you are receiving mental health services.

PURPOSE OF DISCLOSURE: (Check applicable categories)

___ Client's Request
_X_ Other (Specify):

This program assists clients in finding and maintaining jobs and housing. In order to successfully do this we have developed relationships with potential employers and landlords that know that we work with clients who are receiving mental health services. If you refuse to sign this authorization DMH will not be able to contact potential employers and landlords on your behalf to assist you with finding and maintaining jobs and housing.

Will the agency receive any benefits for the disclosure of this information? ___ Yes _X_ No

I understand that PHI used or disclosed as a result of my signing this Authorization may not be further used or disclosed by the recipient unless such use or disclosure is specifically required or permitted by law.

EXPIRATION DATE: This authorization is valid until the following date: ____/____/____
Month Day Year

AUTHORIZATION FOR REQUEST OR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH ("LACDMH")

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATON:

Right to Receive a Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Right to Revoke This Authorization - I understand that I have the right to revoke this Authorization at any time by telling DMH in writing. I may use the Revocation of Authorization at the bottom of this form, mail or deliver the revocation to:

_____ _____

Contact person Agency Name

_____ _____

Street Address City, State, Zip

I also understand that a revocation will not affect the ability of DMH or any health care provider to use or disclose the health information for reasons related to the prior reliance on this Authorization.

Conditions. I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. However, DMH may condition the provision of research-related treatment on obtaining an authorization to use or disclose protected health information created for that research-related treatment. (In other words, if this authorization is related to research that includes treatment, you will not receive that treatment unless this authorization form is signed.)

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____

Signature of Client / Personal Representative Date

If signed by other than the client, state relationship and authority to do so: _____

REVOCATION OF AUTHORIZATION

SIGNATURE OF CLIENT/LEGAL REP: _____

If signed by other than client, state relationship and authority to do so: _____

DATE: ____/____/____

Month Day Year

DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE

SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
TRANSPORTATION OF CONSUMERS AND THEIR FAMILY MEMBERS	**202.22**	**04/15/05**	**1 of 4**
APPROVED BY: Director	SUPERSEDES **202.22**	ORIGINAL ISSUE DATE **02/01/01**	DISTRIBUTION LEVEL(S) **1**

PURPOSE

1.1 To provide Department of Mental Health (DMH) policy and procedure regarding the transportation of consumers and their family members.

1.2 To ensure that transportation of consumers and any of their family members involves as little risk as possible to all individuals.

POLICY

2.1 Under certain circumstances DMH employees may transport consumers and/or their family members in assisting them to access needed benefits, resources, community agencies, mental health programs, etc. This service is provided in a County-business related situation that furthers the consumer's progress toward achieving Service Plan goals. This policy sets the conditions and procedures that must be fulfilled in providing transportation.

2.2 This policy applies only to consumers on voluntary status who want such transportation and only to DMH employees who are willing to provide transportation within the conditions specified in this policy.

2.3 Volunteers may not be permitted to use their personal car or County vehicle for any County business, including, but not limited to, the transportation of clients and their families, other volunteers, County employees, or members of the public.

2.4 An employee may transport a consumer/family member when:

2.4.1 The employee is an approved County mileage permittee (applicable only when using a private vehicle).

2.4.2 The transportation of the consumer/family member is required for effective service delivery and is County-business related.

2.4.3 It has been determined that no other reasonable means of transportation is available to meet the particular transportation need, including, but not limited to, the use of relatives

and friends of the consumer, public transportation, including taxi, and transportation provided by other public agencies such as Los Angeles City's "Dial-a-Ride."

2.4.4 When a County vehicle is not reasonably available, an employee may use his/her private vehicle. A County vehicle is considered reasonably available, in non-emergent circumstances, if it can be obtained no less than ten (10) minutes before the need to transport.

2.5 The transportation of the consumer must be direct from point of origin to destination, without any unrelated stops.

2.6 Transportation of the consumer must be consistent with provisions of the Department's "Illness and Injury Prevention Program" Manual.

2.7 Whenever a consumer is being transported, the driver must ensure that the requirements of the California Vehicle Code are met including the use of passenger seat restraints and the requirement of rear placement of child passenger restraint systems (child safety seats) for children under six (6) years of age or weighing less than 60 pounds.

2.8 Managers at the level of District Chief or higher may set additional requirements and prohibitions for employees in their programs beyond those established by this policy as their needs require. This includes establishing requirements that a second employee accompany the employee/driver and consumer.

2.9 No employee shall transport an individual who:

2.9.1 Is subject to involuntary treatment or custody under Welfare and Institutions Code, Sections 5150 or 5250; or

2.9.2 Is subject to a Conservatorship or Guardianship, unless accompanied by the Conservator or Guardian, or there is written authority to transport from the Conservator or Guardian; or

2.9.3 Is a ward or dependent child of the Juvenile Court unless written authority has been obtained from the Probation Officer, Children's Services Worker or the Court, as applicable; or

2.9.4 Is under the influence of alcohol or an illegal substance.

2.10 Motorcycles and scooters may never be used to transport a mental health consumer/family member(s).

SUBJECT:	POLICY NO.	EFFECTIVE DATE	PAGE
TRANSPORTATION OF CONSUMERS AND THEIR FAMILY MEMBERS	**202.22**	**04/15/05**	**3 of 4**

PROCEDURE

3.1 The procedures below shall be followed whenever DMH employees are considering, planning, and/or providing transportation for consumers/family members.

3.1.1 Employees shall determine whether transporting the consumer/family member is required for effective service delivery.

3.1.2 Employees shall determine whether the transportation need can reasonably be met by other means, i.e., relatives, caretaker, friends, taxi, public transportation. If so, other means shall be used.

3.1.3 Employees shall determine whether they know the consumer and his/her history well enough to be certain of the consumer's cooperation during transport.

3.1.4 Employees shall discuss with the consumer/family member the possibility of providing transportation for them, including the requirement for the use of proper safety precautions (seat belts) and determine whether this would be acceptable to them.

3.1.5 Employees shall determine whether a County vehicle is reasonably available. A County vehicle is considered reasonable available, in non-emergent circumstances, if it can be used no less than ten (10) minutes before the need to transport. If so, the County vehicle is to be used. If not, employees who are mileage permittees may provide transportation in their private vehicles.

3.1.6 Whenever employees are uncertain that transporting a consumer/family member in a specific instance is safe and/or appropriate, they are to consult their supervisor **prior to providing transportation**.

3.1.7 Prior to transporting passengers, drivers must ensure that the requirements of the California Department of Motor Vehicles Vehicle Code are met for the use of passenger seat belts and the rear placement of approved child passenger restraint systems (child safety seats) for the transportation of children under 60 pounds or less than six (6) years old.

3.1.7.1 The DMH Administrative Support Bureau should be contacted to obtain child safety seats.

SUBJECT:	POLICY NO.	EFFECTIVE DATE	PAGE
TRANSPORTATION OF CONSUMERS AND THEIR FAMILY MEMBERS	**202.22**	**04/15/05**	**4 of 4**

3.1.8 Employees shall document in the consumer's chart their transportation of consumers/family members, including the rationale for transporting them and consultation with their supervisor, when applicable.

AUTHORITY
Department of Mental Health Policy
DMH "Illness and Injury Prevention Program" Manual
California Department of Motor Vehicles Vehicle Code, Sections 27315 and 27360(b)
National Highway Transportation Safety Administration Guidelines

REVIEW DATE This policy shall be reviewed on or before April 2010.